IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
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Boise, Idaho 83720-0036
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August 27, 2009

Rex Redden
Idaho Falls Group Home #1 Bellin
P.O. Box 50457
Idaho Falls, ID 83405-0457

RE: Idaho Falls Group Home #1 Bellin, provider #13G024

Dear Mr. Redden:

This is to advise you of the findings of the Medicaid/Licensure survey of Idaho Falls Group Home #1 Bellin, which was conducted on August 21, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **September 9, 2009,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by September 9, 2009. If a request for informal dispute resolution is received after September 9, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G024	A. BUILDING _____ B. WING _____	08/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #1 BELLIN	1664 SOUTH BELLIN IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Michael Case, LSW, QMRP, Team Lead Matt Hauser, QMRP Common abbreviations/symbols used in this report are: HRC - Human Rights Committee ITTP - Interdisciplinary Treatment Team Plan MAR - Medication Administration Record QMRP - Qualified Mental Retardation Professional	W 000	RECEIVED SEP 14 2009 FACILITY STANDARDS	
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the human rights committee for 1 of 2 individuals (Individual #1) whose restrictive interventions were reviewed. This resulted in a lack of protection of an individual's rights through prior approvals of restrictive interventions. The findings include: 1. Individual #1's 10/30/08 ITTP stated she was a 31 year old female whose diagnoses included	W 262	W 262 1. All individuals have the potential to be affected by this practice. Human Rights Committee consent will be obtained for all individuals requiring one-on-on staffing. 2. The QMRP will review the need for one-on-one staff and obtain consent from the Human Rights Committee members. The QMRP will review the need for one-on-one staffing and receive consent from the Human Rights Committee members on a bi-annual basis. 3. Target date for completion will be October 21, 2009.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Andrea Rees — TITLE: Admin. Dos. — (X6) DATE: 9/8/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 262	Continued From page 1 profound mental retardation, autism, and bilateral cataracts. During an entrance conference on 8/17/09 from 8:50 - 9:30 a.m., the QMRP stated Individual #1 had one-on-one staffing due to self-injurious behaviors of head banging, eye pressing, and falls. During observations conducted at the facility on 8/18/09 from 2:00 - 2:55 p.m., and on 8/19/09 from 5:50 - 8:15 a.m. and 9:55 - 11:15 a.m., Individual #1 was noted to have a designated one-on-one staff who remained with her at all times and in all locations of the facility, including Individual #1's bedroom and bathroom. Individual #1's record was reviewed and did not include documentation the facility's HRC had approved the use of one-on-one staffing. When asked during an interview on 8/21/09 from 9:00 - 10:45 a.m., the QMRP stated HRC approval had not been obtained for Individual #1's one-on-one staffing. The facility failed to ensure the HRC approved the use of Individual #1's one-on-one staffing.	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, record review, and staff	W 263		

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W 263	Continued From page 2 interview it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the parent/guardian for 1 of 2 individuals (Individual #1) whose restrictive interventions were reviewed. This resulted in a lack of protection of an individual's rights through prior approvals for restrictive interventions. The findings include: 1. Individual #1's 10/30/08 ITTP stated she was a 31 year old female whose diagnoses included profound mental retardation, autism, and bilateral cataracts. During an entrance conference on 8/17/09 from 8:50 - 9:30 a.m., the QMRP stated Individual #1 had one-on-one staffing due to self-injurious behaviors of head banging, eye pressing, and falls. During observations conducted at the facility on 8/18/09 from 2:00 - 2:55 p.m., and on 8/19/09 from 5:50 - 8:15 a.m. and 9:55 - 11:15 a.m., Individual #1 was noted to have a designated one-on-one staff who remained with her at all times and in all locations of the facility, including Individual #1's bedroom and bathroom. Individual #1's record was reviewed and did not include documentation of written informed consent from the guardian for the use of one-on-one staffing. When asked during an interview on 8/21/09 from 9:00 - 10:45 a.m., the QMRP stated guardian consent had not been obtained for Individual #1's one-on-one staffing. The facility failed to ensure written informed	W 263	W 263 1. All individuals have the potential to be affected by this practice. The QMRP will review the need for one-on-one staffing with the individuals guardian and obtain written informed consent for the use of one-on-one staffing. 2. The QMRP will review the need for one-on-one staffing with the individuals guardian and will obtain written informed consent on an annual basis or as needed for any changes that may occur. 3. Target date for completion will be October 21, 2009.	

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W 263	Continued From page 3 consent from the guardian was obtained for the use of Individual #1's one-on-one staffing.	W 263		
W 277	483.450(b)(1)(ii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Procedures that govern the management of inappropriate client behavior must designate these interventions on a hierarchy to be implemented, ranging from most positive or least intrusive, to least positive or most intrusive. This STANDARD is not met as evidenced by: Based on observation, review of the facility policies and procedures, and staff interview it was determined the facility failed to ensure the mal-adaptive behavior policy included all positive and intrusive behavior interventions on a hierarchy ranging from most positive to most intrusive. This directly impacted 1 of 4 individuals (Individual #1) reviewed, and had the potential to impact 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in interventions being used without the necessary facility approvals. Findings include: The facility's Behavior Modification Program Guidelines, revised 9/19/06, listed approved interventions for maladaptive behaviors in a hierarchy divided into 6 levels. Increased staff supervision to one-on-one staffing was listed under Level 2. Level 1 and 2 interventions were not considered restrictive and did not require guardian consent and HRC approval. During an entrance conference on 8/17/09 from 8:50 - 9:30 a.m., the QMRP stated Individual #1 had one-on-one staffing due to self-injurious behaviors of head banging, eye pressing, and	W 277	W 277 1. All individuals have the potential to be affected by this practice. The Behavior Modification Program Guidelines will be revised to incorporate one-on-one staff supervision as a restrictive intervention which will require guardian consent and HRC approval. 2. The QMRP will revise the Behavior Modification Program Guidelines to incorporate one-on-one staff supervision as a restrictive intervention which will require guardian consent and HRC approval. The QMRP will continue to revise and update the Behavior Modification Program Guidelines on an as needed basis to ensure all positive and intrusive behavior interventions are addressed on the appropriate hierarchy. The QMRP will review the Behavior Modification Program Guidelines with the Human Rights Committee Members to ensure that the hierarchy ranges from most positive to most intrusive on a bi-annual basis. 3. Target date for completion will be October 21, 2009.	

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W 277	Continued From page 4 falls. During observations conducted at the facility on 8/18/09 from 2:00 - 2:55 p.m., and on 8/19/09 from 5:50 - 8:15 a.m. and 9:55 - 11:15 a.m., Individual #1 was noted to have a designated one-on-one staff who remained with her at all times and in all locations of the facility, including Individual #1's bedroom and bathroom. When asked during an interview on 8/21/09 from 9:00 - 10:45 a.m., the QMRP stated one-on-one staffing was restrictive and should be clarified in the policy. The facility failed to ensure one-one-one staff supervision was appropriately identified in the Behavior Modification Program Guidelines as a restrictive intervention.	W 277		
W 365	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure individual medication administration records were maintained for 1 of 4 individuals (Individual #4) whose medication administration records were reviewed. This resulted in the potential for an individual to not receive medications as ordered by the physician. The findings include: 1. Individual #4's 6/24/09 ITTP stated she was a 28 year old female whose diagnoses included profound mental retardation and complex seizure	W 365	W 365 1. All individuals have the potential to be affected by this practice. The Home Supervisor and the Medical Coordinator will retrain all staff on how to accurately maintain all individuals medication administration records. The Medication Error Policy has been revised to indicate the steps that are to be taken if a medication administration record has not been accurately documented. 2. The Home Supervisor and Medical Coordinator will conduct on-going training on how to accurately document and maintain all individuals medication administration records during monthly staff meetings. The QMRP will attend all monthly staff meetings to ensure that on-going training is being provided to staff on how to accurately maintain all individuals medication administration records. 3. Target date for completion will be October 21, 2009.	

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W 365	Continued From page 5 disorder. Her Physician's Orders, dated 7/6/09, stated she received Lamictal (an anticonvulsant drug) 225 mg each morning, Mysoline (an anticonvulsant drug) 100 mg twice daily, Topamax (an anticonvulsant drug) 50 mg each morning, Protonix (an antiulcer drug) 40 mg three times daily, Folic Acid (a B-complex vitamin drug) 1 mg daily, Lorazepam (an anxiolytic drug) 0.5 mg three times daily, Keppra (an anticonvulsant drug) 1500 mg each morning, Cryselle (an hormonal drug) 1 tab each morning, and Felbatol (an anticonvulsant drug) 400 mg each morning. During an observation on 8/19/09 from 5:50 - 8:15 a.m., Individual #4 was observed to participate in a self administration of medication program. During that time, the staff assisting Individual #4 stated the 8/19/09 a.m. medications were missing from the blister packs and she would be pulling the medications from the last day of the month. When asked during the observation about the missing drugs, the staff stated she believed they had been dropped during an overnight outing 8/16 - 17/09, but the incident was not documented on the back of the MAR as required. When asked how she could ensure the medications had not already been given, the staff stated she could not without accurate documentation on the back of the MAR. Without accurate documentation on the back of the MAR, it would not be possible to ensure Individual #4 had not previously received her 8/19/09 a.m. medications. The staff stopped the medication administration process and contacted the facility nurse to ensure the medications had not already been given.	W 365		

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W 365	Continued From page 6 During an interview on 8/21/09 from 9:00 - 10:45 a.m., the Medical Coordinator stated if medications were dropped, staff were to document on the back of the MAR, contact the nurse, and pull medications from the last day of the month. Individual #4's a.m. medications had been dropped on 8/17/09 while Individual #4 was out of the facility with staff. However, the staff failed to document, and had pulled the medications from 8/18/09 rather than the end of the month. When asked if there should then have been documentation regarding missing medications for 8/18/09, the Medical Coordinator stated there should have been. The facility failed to ensure Individual #4's medication administration records were accurately maintained.	W 365		
W 426	483.470(d)(3) CLIENT BATHROOMS The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. This STANDARD is not met as evidenced by: Based on environmental review and staff interview, it was determined the facility failed to ensure hot water temperatures were maintained at or below 110 degrees Fahrenheit for 8 of 8 individuals (Individuals #1 - #8) who were unable to regulate water temperatures independently. This resulted in an increased risk of scald injuries during hand washing and bathing. The findings include: 1. Hot water temperatures were obtained at the	W 426	W 426 1. All individuals have the potential to be affected by this practice. The Home Supervisor and Lead Worker will conduct weekly water temperature checks in the home. 2. The Home Supervisor and Lead Worker will be responsible for conducting weekly water temperature checks in the home. If the water temperature is above 110 degrees Fahrenheit they will immediately notify the Administrator Designee so water temperatures can be adjusted to the appropriate temperature. Maintenance Personnel will conduct monthly water temperature checks in the home to ensure the water temperature is below 110 degrees Fahrenheit. 3. Target date for completion will be October 21, 2009.	

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W 426	Continued From page 7 facility during an environmental review on 8/19/09 from 3:00 - 3:20 p.m. and were recorded as follows: Hallway bathroom - 117.5 degrees Medication bathroom - 117.5 degrees When asked if the individuals residing in the facility could regulate water temperatures, the Home Supervisor, who was present, stated none of the individuals residing at the facility were able to self regulate water temperatures. At that time, the Home Supervisor was notified of the water temperatures being too high. The facility failed to ensure water temperatures were maintained at or below 110 degrees Fahrenheit. Note: Water temperatures were re-checked on 8/20/09 at 4:20 p.m. and found to be within the acceptable range.	W 426		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure individuals' adaptive equipment was kept in good repair for 3 of 7 individuals (Individuals #2, #3 and #5) who required adaptive equipment for mobility and	W 436		

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W 436	Continued From page 8 possitioning. This resulted in individuals' wheelchairs and an individual's positioning device being in disrepair. The findings include: 1. Observations were conducted at the facility on 8/18/09 from 2:00 - 2:55 p.m. and on 8/19/09 from 9:55 - 11:15 a.m. During that time the following concerns were noted: - For Individual #2: There was a blue foam wedge used to position her legs in bed that had multiple rips and sections of foam missing. The chest strap of her wheelchair was soiled. - For Individual #3: There were 2 one-inch holes on the left side of the headrest cover, the backrest had a 2 inch section on the top left that was peeling, and the upper leg cushion had a 1 inch by 3 inch hole. - For Individual #5: The cover on the foot box was ripped across the entire bottom edge and approximately 8 inches up the right side. There were uncovered foam pads on the foot rest supports that were ripped and covered with tape. The backrest cover had a 3 inch rip on the left side. The tray for Individual #5's wheelchair was missing. When asked during the observation on 8/19/09 at 10:45 a.m., staff stated the tray was missing because it was broken. When asked during an interview on 8/21/09 from 9:00 - 10:45 a.m., the QMRP stated the concerns with wheelchairs has been ongoing, and the facility has been working with the local medical supply company to ensure wheelchairs were appropriately maintained. The facility failed to ensure individuals'	W 436	W 436 1. All individuals have the potential to be affected by this practice. All staff will be required to complete a damage report anytime any adaptive equipment is noticed to be in poor repair. The damage report will be turned into the Home Supervisor. The Home Supervisor will immediately contact the durable medical equipment provider to notify them of the damaged equipment. The Home Supervisor will then document the date, time, and the person that they spoke with from the durable medical equipment company. All staff will be retrained on how to appropriately clean and disinfect adaptive equipment in the home. 2. The Home Supervisor will be responsible for turning in the damage reports to the QMRP daily. The QMRP will then monitor the damage reports to ensure the durable medical equipment company is following up on all needed repairs in a timely manner. The QMRP will document on the damage report when the adaptive equipment repairs have been completed by the durable medical equipment company. The completed damage reports will then be forwarded to the Administrator Designee to ensure that all adaptive equipment is being appropriately maintained and repaired in a timely manner. The Home Supervisor will ensure that all adaptive equipment is clean and disinfected with weekly on-site observation. 3. Target date for completion will be October 21, 2009.	

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W 436	Continued From page 9 wheelchairs and positioning devices were kept in good repair.	W 436		

Bureau of Facility Standards

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MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194	MM194 Refer to W262	
MM196	16.03.11.075.10(c) Consent of Parent or Guardian Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.	MM196	MM196 Refer to W263 RECEIVED SEP 14 2009 FACILITY STANDARDS	
MM269	16.03.11.100.04 Insect and Rodent Control Insect and Rodent Control. The facility must be maintained free from insects, rodents and other pests. Chemicals (pesticides) used in the control program must be selected, used, and stored in the following manner: This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all areas were free from insects for 8 of 8 individuals (Individuals #1 - #8) who resided in the facility. This resulted in ants being present in the facility's kitchen. The findings include: 1. During an environmental survey on 8/19/09 from 3:00 - 3:30 p.m., ants were noted to be crawling on the wall in the area of the kitchen. The maintenance staff, who was present during the environmental survey, stated ants have been a problem in the facility.	MM269	MM269 1. All individuals have the potential to be affected by this practice. An insect and rodent control company is currently contracting with the facility to alleviate all insect and rodent issues at all facilities. 2. Anytime evidence of insect or rodent infestation will be reported immediately to the Administrator Designee. The Administrator Designee will then immediately contact the contracting insect and rodent control company to resolve the issue. 3. Target date for completion will be October 21, 2009.	

Andrea Ross
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Admin. Dir.
TITLE

9/8/09
(X6) DATE

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G024	A. BUILDING _____ B. WING _____	08/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #1 BELLIN	1664 SOUTH BELLIN IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM269	Continued From page 1 The facility failed to ensure the environment was free from insects.	MM269		
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include: During an environmental survey conducted on 8/19/09 from 3:00 - 3:30 p.m., the following concerns were noted: - There was food debris in the bottom of the oven drawer. - Two medium fry pans contained baked on grease. - Two pots and 1 lid contained a white powder like substance. - The hall bathroom toilet was missing a bolt cover. - The medication bathroom toilet was missing a	MM380	MM380 1. All individuals have the potential to be affected by this practice. All employees are responsible for completing a damage report on all repairs that are needed in the facility. The damage report is then turned in to the supervisor for review. The supervisor then submits the damage report to the QMRP for follow-up. 2. All repairs that are needed will be completed by maintenance personnel. All staff will be retrained by the Home Supervisor and Lead Worker on all deep cleaning duties. The Home Supervisor and Lead Worker will conduct a walk through of the home on a weekly basis to ensure deep cleaning duties and repairs of the facility are being preformed. 3. Target date for completion will be October 21, 2009.	

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MM380	Continued From page 2 bolt cover. - There was a 4 inch by 4 inch patched section on the living room closet door that was missing paint. - The left closet door in the living room was detached from the rail. - There was a 3 inch by 8 inch section of wall in the living room to the right of the closet that was patched and missing paint. - There was a 6 inch by 6 inch section of wall under the living room window that was patched and missing paint. - There was a 4 foot section of wall to the right of the door in Individual #5's bedroom that was marred and missing paint. - There was a 2 foot section of corner edging to the left of Individual #5's dresser that was missing plaster and paint. - There was a 4 inch by 4 inch section of plaster missing to the left of Individual #5's dresser exposing the metal understructure. - The cord was broken on the right window blind in Individual #5's bedroom. - The paint in Individual #5's windowsill was peeling. - The center drawer under Individual #6's bed was broken. - The top of the blind in the bedroom shared by Individual #4 and Individual #8 was broken and	MM380		

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MM380	Continued From page 3 missing a section of the rail. - There was a 3 and 1/2 foot section of wall edging to the left, and a 4 foot section of wall edging to the right, of Individual #2's dresser that was missing plaster and paint, exposing the metal understructure. - There was a 4 inch by 3 inch hole in the wall to the right of the sink in the medication room. - The right cabinet door in the back bathroom was missing. - There was a 3 inch by 5 inch section of wall to the right of the back bathroom door that had chipped and peeling paint. - There was a 2 inch by 3 inch hole in the wall below the back bathroom window. The facility failed to ensure environmental repairs were completed.	MM380		
MM429	16.03.11.120.11 Equipment and Supplies for Resident Care Equipment and Supplies for Resident Care. Adequate and satisfactory equipment and supplies must be provided to enable the staff to satisfactorily serve the residents. This Rule is not met as evidenced by: Refer to W436.	MM429	MM429 Refer to W436	
MM520	16.03.11.200.03(a) Establishing and Implementing polices The administrator will be responsible for establishing and implementing written policies	MM520	MM520 Refer to W277	

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MM520	Continued From page 4 and procedures for each service of the facility and the operation of its physical plant. He must see that these policies and procedures are adhered to and must make them available to authorized representatives of the Department. This Rule is not met as evidenced by: Refer to W277.	MM520		
MM570	16.03.11.210.05(b) Meidcations and Treatments A record of all medications and treatments prescribed and administered; and This Rule is not met as evidenced by: Refer to W365.	MM570	MM570 Refer to W365	
MM696	16.03.11.250.09(d)(i) Refrigerator and Freezer Each refrigerator and freezer must be equipped with a reliable, easily read thermometer. Refrigerators must be maintained at forty-five (45) degrees Fahrenheit or below. Freezers must be maintained at zero degrees - ten (0-10) degrees Fahrenheit or below. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure each refrigerator and freezer was equipped with a reliable, easily read thermometer for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in potential for food to be stored at unsafe temperatures. The findings include: An environmental survey conducted on 8/19/09 from 3:00 - 3:30 p.m., showed there was no thermometer in the refrigerator of the refrigerator/freezer combination which was located in the garage. The refrigerator contained milk, whipped topping, sour cream, yogurt, and	MM696	MM696 1. All individuals have the potential to be affected by this practice. Thermometers have been purchased and have been placed in all refrigerators in the facility. 2. Maintenance personnel will check for placement of thermometers during monthly maintenance checks of the facility. If a thermometer is found to be missing, maintenance personnel will immediately purchase a new one for the facility. 3. Target date for completion will be October 21, 2009.	

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MM696	Continued From page 5 cheese. The temperature of the food was checked and found to be below 45 degrees. The Home Supervisor, who was present during the review, stated thermometers would be obtained for the facility. The facility failed to ensure each freezer was equipped with a reliable, easily read thermometer.	MM696		